FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005405

Facility Name: HILLTOP CONVALESCENT CENTER

Address: 910 WEST POLK (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: (217) 345-7006 **Fax #** (217) 345-6017

IDPA ID Number: 370776670001

Date of Initial License for Current Owners: 07/01/1958

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** (217) 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/02 to 07/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) JERRY W. JENNINGS
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	75,058	7,394	5,567	88,019		88,019		88,019			1
2	Food Purchase		69,225		69,225		69,225	(816)	68,409			2
3	Housekeeping	28,246	7,630		35,876		35,876		35,876			3
4	Laundry	17,864	9,533		27,397		27,397		27,397			4
5	Heat and Other Utilities			55,643	55,643		55,643		55,643			5
6	Maintenance	17,033	22,565	38,721	78,319		78,319	1,088	79,407			6
7	Other (specify):*											7
8	**TOTAL General Services**	138,201	116,347	99,931	354,479		354,479	272	354,751			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	689,579	127,414	70,068	887,061	(89,964)	797,097	3,748	800,845			10
10a	Therapy	8,468	1,186	188,965	198,619	(188,965)	9,654		9,654			10a
11	Activities	24,809	1,825		26,634		26,634		26,634			11
12	Social Services	30,867		3,317	34,184		34,184		34,184			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	753,723	130,425	274,350	1,158,498	(278,929)	879,569	3,748	883,317			16
	C. General Administration											
17	Administrative	58,245		15,569	73,814	1,777	75,591	28,361	103,952			17
18	Directors Fees											18
19	Professional Services			137,892	137,892		137,892	(129,722)	8,170			19
20	Dues, Fees, Subscriptions & Promotions			10,430	10,430		10,430	(3,925)	6,505			20
21	Clerical & General Office Expenses	29,283	9,350	5,738	44,371		44,371	21,919	66,290			21
22	Employee Benefits & Payroll Taxes			157,061	157,061		157,061	12,847	169,908			22
23	Inservice Training & Education			1,111	1,111		1,111	785	1,896			23
24	Travel and Seminar			7,197	7,197	(6,279)	918	399	1,317			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			94,795	94,795		94,795	168	94,963			26
27	Other (specify):*			10,591	10,591		10,591	(10,591)				27
28	**TOTAL General Administration**	87,528	9,350	440,384	537,262	(4,502)	532,760	(79,759)	453,001			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	979,452	256,122	814,665	2,050,239	(283,431)	1,766,808	(75,739)	1,691,069			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	36	13,140	1
2		Skilled Pediatric (SNF/PED)			2
3	72	Intermediate (ICF)	72	26,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	108	TOTALS	108	39,420	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	227	9	3,283	3,519	8
9	SNF/PED					9
10	ICF	9,762	7,212		16,974	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,989	7,221	3,283	20,493	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.99%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/1958

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 3,283

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 07/31/03 Fiscal Year: 07/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER #0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			15,350	15,350		15,350	6,876	22,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			32,225	32,225		32,225		32,225			33
34	Rent-Facility & Grounds							3,552	3,552			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,575	47,575		47,575	10,428	58,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					283,431	283,431		283,431			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,130	59,130		59,130		59,130			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			59,130	59,130	283,431	342,561		342,561			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	979,452	256,122	921,370	2,156,944		2,156,944	(65,311)	2,091,633			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,749	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(94)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,864)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(485)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,969)	27		24
25	Fund Raising, Advertising and Promotional	(3,454)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,758)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule VENDING	(816)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,691)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(55,620)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (55,620)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (65,311)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		188,965	10a	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		3,136	10	42
43	Prescription Drugs	X		71,414	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule IV'S	X		4,010	10	45
46	Other-Attach Schedule OXYGEN	X		15,906	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 283,431		47

STATE OF ILLINOIS

HILLTOP CONVALESCENT CENTER

ID# 0005405

Report Period Beginning: 08/01/02

Ending: 07/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	179	0	0	0	0	0	0	0	0	0	179	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(131,093)	0	0	0	0	0	0	0	0	0	(131,093)	19
20	Fees, Subscriptions & Promotions	(3,939)	0	0	0	0	0	0	0	0	0	0	(3,939)	20
21	Clerical & General Office Expenses	(94)	0	0	0	0	0	0	0	0	0	0	(94)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(179)	0	0	0	0	0	0	0	0	0	(179)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(10,591)	0	0	0	0	0	0	0	0	0	0	(10,591)	27
28	**TOTAL General Administration**	(14,624)	(131,093)	0	0	0	0	0	0	0	0	0	(145,717)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,624)	(131,093)	0	0	0	0	0	0	0	0	0	(145,717)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 **Report Period Beginning:** 08/01/02 **Ending:** 07/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,749	0	0	0	0	0	0	0	0	0	0	5,749	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,749	0	0	0	0	0	0	0	0	0	0	5,749	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,875)	(131,093)	0	0	0	0	0	0	0	0	0	(139,968)	45

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
H. RAYMOND KLEIN	78.18	D'ADRIAN CONVALESCENT CENTER	GODFREY	Nrsg Home Mngrs	SPRINGFIELD	MANAGEMENT
DANA KLEIN KAVY	4.24	JACKSONVILLE CONVALESCENT CENTER	JACKSONVILLE			
PHILIP KLEIN	4.24	MEADOW MANOR, INC.	TAYLORVILLE			
LISA KLEIN GILDAR	4.24	MENARD CONVALESCENT CENTER	PETERSBURG			
DAVID & RAQUEL KLEIN	4.55	SUNRISE MANOR OF VIRDEN	VIRDEN			
JERRY & PAULA JENNINGS	4.55					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEE	$ 137,607	NURSING HOME MANAGERS, INC.	39.39%	$	$ (137,607)	1
2	V	VAR	SEE ATTACHED SCHEDULE		NURSING HOME MANAGERS, INC.	39.39%	75,473	75,473	2
3	V	19	ACCOUNTING		NURSING HOME MANAGERS, INC.-DIRECT ALLOCATION	39.39%	6,514	6,514	3
4	V	24	TRAVEL	179	TO TRANSFER 31% OF HOME OFFICE TRAVEL			(179)	4
5	V	17	ADMINISTRATIVE TRAVEL		TO ADMINISTRATIVE - PER DESK REVIEW		179	179	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 137,786			$ 82,166	$ * (55,620)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	JERRY JENNINGS	CONTROLLER	MANAGEMENT	4.55					$ 12,744	17 - 7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	78.18					1,702	17 - 7	2
3											3
4											4
5		H. RAYMOND KLEIN AND JERRY JENNINGS WERE PAID BY NURSING HOME									5
6		MANAGERS, INC., A RELATED ORGANIZATION. TOTAL COMPENSATION									6
7		OF $10,010 FOR H. RAYMOND KLEIN WAS ALLOCATED AMONG THE SIX									7
8		RELATED NURSING HOMES BASED UPON 10 HOURS PER WEEK. TOTAL									8
9		COMPENSATION OF $76,170 FOR JERRY JENNINGS WAS ALLOCATED AMONG									9
10		THE SIX RELATED NURSING HOMES BASED UPON 35 HOURS PER WEEK.									10
11											11
12											12
13								TOTAL	$ 14,446		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 WEST LAWRENCE - SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE ATTACHED SCHEDULE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	$	46,299	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	44,804	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,495)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	33,720	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,225	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	35,146	8
1999	34,533	9
2000	35,172	10
2001	29,241	11
2002	31,126	12

LINE 2: 2001 R. E. TAX BILL	$29,241	LINE 4: 2ND INSTALL. 2002 TAXES	$15,563
1ST INSTALL. 2002 TAXES	$15,563	7/12 OF $31,126 =	$18,157
TOTAL LINE 2	$44,804	TOTAL LINE 4	$33,720

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HILLTOP CONVALESCENT CENTER COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0005405

CONTACT PERSON REGARDING THIS REPORT JERRY W. JENNINGS

TELEPHONE (217) 787-8530 FAX #: (217) 787-9840

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-1-00706-000	HILLTOP NURSING HOME	$ 31,125.74	$ 31,125.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,125.74	$ 31,125.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,709 B. General Construction Type: Exterior MASONRY Frame WOOD & STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1966	$ 5,295	1
2					2
3	TOTALS			$ 5,295	3

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1966		$ 253,434	$	30	$	$	$ 253,434	4
5	36			1972	240,043		30			240,043	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1975	2,877		10			2,877	9
10	LANDSCAPING			1980	1,417		5			1,417	10
11	IMPROVEMENT			1979	17,131		15			17,131	11
12	IMPROVEMENT			1981	4,330		VARIOUS			4,330	12
13	IMPROVEMENT			1982	3,570		15			3,570	13
14	IMPROVEMENT			1983	3,583		15			3,583	14
15	IMPROVEMENT			1984	2,461		15			2,461	15
16	IMPROVEMENT			1985	14,201	395	15		(395)	14,201	16
17	AIR CONDITIONER			1986	1,620	84	10		(84)	1,620	17
18	CONDENSOR			1986	3,068	160	15		(160)	3,068	18
19	ROOF			1986	19,843	1,032	15		(1,032)	19,843	19
20	CUBICAL TRACKS			1987	997	32	20	49	17	849	20
21	AIR CONDITIONER			1987	1,149	36	10		(36)	1,149	21
22	AIR CONDITIONER			1988	3,145	100	10		(100)	3,145	22
23	WATER HEATER			1988	982	31	15	60	29	982	23
24	WATER HEATER			1989	2,194	70	15	147	77	1,996	24
25	AIR CONDITIONER			1991	1,959	62	10		(62)	1,959	25
26	SIDEWALK			1991	3,120	99	20	156	57	1,976	26
27	WIRING			1992	1,384	44	20	69	25	818	27
28	AIR CONDITIONER			1992	1,474	47	10		(47)	1,474	28
29	DOOR ALARM, FURNACE, IMPROVEMENT			1993	6,664	212	15	444	232	4,663	29
30	LANDSCAPING			1993	2,824	188	10	144	(44)	2,824	30
31	BLACKTOP - PER 1991 AUDIT			1990	2,186		15	146	146	1,460	31
32	AIR CONDITIONER			1994	1,613	41	10	161	120	1,477	32
33	LIGHTING			1995	2,729	70	10	273	203	2,320	33
34	AIR CONDITIONER			1996	1,112	28	8	139	111	985	34
35	EXHAUST FAN, FLOORING, WATER HEATERS			1996	5,048	129	15	336	207	2,525	35
36	REMODELING - WALLS			1996	1,080	28	30	36	8	252	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	1996	$ 1,611	$ 41	15	$ 108	$ 67	$ 716	37
38	REMODELING - WALLS	1997	10,714	275	30	358	83	2,232	38
39	AIR CONDITIONERS	1999	3,185	82	10	318	236	1,461	39
40	ROOF	1999	68,332	1,752	20	3,416	1,664	14,235	40
41	FURNACE	2000	1,273	33	15	84	51	325	41
42	AIR CONDITIONERS	2001	1,404	36	10	141	105	421	42
43	GAZEBO	2001	1,374	35	15	92	57	260	43
44	SMOKE DETECTORS	2001	1,648	42	15	110	68	183	44
45	FIRE DAMPERS	2002	1,451	37	15	97	60	145	45
46	FURNACE	2002	2,200	56	15	147	91	220	46
47	EXHAUST RENOVATIONS	2002	8,298	213	15	553	340	784	47
48	FIRE / RADIATION DAMPERS	2002	1,770	45	15	118	73	148	48
49	AIR CONDITIONERS	2003	3,200	72	10	293	221	293	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 713,698	$ 5,607		$ 7,995	$ 2,388	$ 619,855	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 134,472	$ 6,381	$ 11,335	$ 4,954	VARIOUS	$ 87,509	71
72	Current Year Purchases	20,391	3,362	1,769	(1,593)	VARIOUS	1,769	72
73	Fully Depreciated Assets	158,092					158,092	73
74	Assets No Longer in Service	(58,078)					(58,078)	74
75	TOTALS	$ 254,877	$ 9,743	$ 13,104	$ 3,361		$ 189,292	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 973,870	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,350	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 21,099	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,749	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 809,147	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 8	hrs	$	1,851	$	82,151	$	1,851	$ 82,151	1
2	Licensed Speech and Language Development Therapist	39 - 8	hrs		224		14,378		224	14,378	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 8	hrs		1,941		92,436		1,941	92,436	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 8	# of prescrpts					71,414		71,414	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): IV'S, OXYGEN, LAB	39 - 8						23,052		23,052	13
14	TOTAL			$	4,016	$	188,965	$ 94,466	4,016	$ 283,431	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 07/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 81,948	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	325,995		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,197		6
7	Other Prepaid Expenses	38,241		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 464,381	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,295		13
14	Buildings, at Historical Cost	711,511		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	311,386		16
17	Accumulated Depreciation (book methods)	(873,815)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 154,377	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 618,758	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 92,497	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,949		31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,720		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,758		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 152,976	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 152,976	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 465,782	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 618,758	$	48

***(See instructions.)**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 544,002	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 544,002	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	123,626	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(201,846)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (78,220)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 465,782	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,371,675	1
2	Discounts and Allowances for all Levels	(169,169)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,202,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,321	6
7	Oxygen	12,969	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 56,290	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	780	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 780	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	854	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 854	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending $816, Admit Fees $40, W/A $54	910	28
28a	Gain on Invest $19,405, IL Treas $<175>	19,230	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 20,140	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,280,570	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	354,479	31
32	Health Care	1,158,498	32
33	General Administration	537,262	33
	B. Capital Expense		
34	Ownership	47,575	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	59,130	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,156,944	40
41	**Income before Income Taxes (line 30 minus line 40)****	123,626	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 123,626	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 50,557	$ 24.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,002	5,164	99,896	19.34	3
4	Licensed Practical Nurses	11,468	11,723	163,602	13.96	4
5	Nurse Aides & Orderlies	40,553	41,301	375,524	9.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	830	867	8,468	9.77	8
9	Activity Director	1,376	1,517	14,121	9.31	9
10	Activity Assistants	1,383	1,435	10,688	7.45	10
11	Social Service Workers	3,150	3,244	30,867	9.52	11
12	Dietician					12
13	Food Service Supervisor	1,556	2,038	22,862	11.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,178	8,321	52,196	6.27	15
16	Dishwashers					16
17	Maintenance Workers	2,519	2,555	17,033	6.67	17
18	Housekeepers	4,774	4,836	28,246	5.84	18
19	Laundry	2,645	2,793	17,864	6.40	19
20	Administrator	2,000	2,080	58,245	28.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,782	2,962	29,283	9.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,216	92,916	$ 979,452 *	$ 10.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	182	$ 5,567	1 - 3	35
36	Medical Director	120	12,000	9 - 3	36
37	Medical Records Consultant	16	559	10 - 3	37
38	Nurse Consultant	530	24,648	10 - 3	38
39	Pharmacist Consultant	76	1,550	10 - 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	60	3,317	12 - 3	45
46	Other(specify)				46
47	Administrative Consultant	488	15,569	17 - 3	47
48	Medicare Consultant	160	20,286	10 - 3	48
49	TOTAL (lines 35 - 48)	1,632	$ 83,496		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	250	$ 8,893	10 - 3	50
51	Licensed Practical Nurses	420	13,532	10 - 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	670	$ 22,425		53

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ARACELI HENSON	ADMINISTRATOR	0	$ 58,245
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,245

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 15,569
TOTAL (agree to Schedule V, line 17, col. 3)	$ 15,569
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT	$ 137,607
C S C	CORP. REPRESENTATION	285
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 137,892

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,353
Unemployment Compensation Insurance	7,981
FICA Taxes	73,093
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE CAFETERIA PLAN	27,524
EMPLOYEE LIFE INSURANCE	2,312
VACCINES	1,958
HOLIDAY PARTY	320
GIFT CERTIFICATES	520
NURSING HOME MANAGERS ALLOCATION	12,847
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,908

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
VACCINES	22	$ 1,958
HOLIDAY PARTY	22	320
GIFT CERTIFICATES	22	520
TOTAL		$ 2,798

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,745
Health Care Worker Background Check	696
(Indicate # of checks performed 58)	
PUBLIC RELATIONS	3,454
CHAMBER OF COMMERCE DUES	485
FRANCHISE FEES	50
NURSING HOME MANAGERS ALLOC.	14
Less: Non-allowable Fees	(485)
Less: Public Relations Expense	(3,454)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,505

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MISCELLANEOUS MILEAGE REIMB.	918
NURSING HOME MANAGERS ALLOC.	578
TSF TO ADMINISTRATIVE	(179)
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,317

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HILLTOP CONVALESCENT CENTER # 0005405 Report Period Beginning: 08/01/02 Ending: 07/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINT	9/90	$ 1,925	3 YRS	$	$	$	$	$	$	$	$	$
2	DECORATION	7/93	1,884	3 YRS									
3	PAINT & WALLCOVER	7/94	3,986	3 YRS									
4	PAINT & WALLPAPER	7/96	3,825	3 YRS									
5	PAINT & WALLPAPER	3/97	5,058	3 YRS	843								
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 16,678		$ 843	$	$	$	$	$	$	$	$

Facility Name & ID Number HILLTOP CONVALESCENT CENTER **#** 0005405 **Report Period Beginning:** 08/01/02 **Ending:** 07/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,827** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **59,130**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

PAGES 3 & 4 - SCHEDULE V

LINE 27 - OTHER GENERAL ADMINISTRATION

BAD DEBT	$	5,969
SALES TAX		2,864
ILLINOIS RT TAX		1,758
TOTAL LINE 27 - COLUMN 3	$	10,591

DETAIL OF RECLASSIFICATIONS - COLUMN 5

			LINE #
RECLASS FROM:			
OXYGEN	$	(15,906)	10
MEDICARE DRUGS		(71,414)	10
MEDICARE LAB FEES		(3,136)	10
MEDICARE IV'S		(4,010)	10
PHYSICAL THERAPY		(92,436)	10A
SPEECH THERAPY		(14,378)	10A
OCCUPATIONAL THERAPY		(82,151)	10A
RECLASS TO: ANCILLARY SERVICES	$	283,431	39
RECLASS TO:			
NURSE CONSULTANT MILEAGE	$	4,502	10
ADMINISTRATIVE CONSULTANT MILEAGE		1,777	17
RECLASS FROM: TRAVEL	$	(6,279)	24

PAGE 2 - SCHEDULE III- QUESTION K

OF BEDS CERTIFIED MEDICARE

08/01/02 - 12/31/02	10 BEDS
01/01/03 - 07/31/03	25 BEDS

PAGE 13 - SCHEDULE XI - SECTION E

RECONCILIATION OF DEPRECIATION

LINE 83 - STRAIGHT LINE DEPRECIATION	$ 21,099
NURSING HOME MANAGERS ALLOCATION	1,127
SCHEDULE V - LINE 30 - COLUMN 8	$ 22,226

PAGE 19 - SCHEDULE XVII

RECONCILIATION OF INCOME

NET INCOME - LINE 43	$ 123,626
* MANAGEMENT FEE 07/31/02	(16,712)
* MANAGEMENT FEE 07/31/03	9,356
RENTAL INCOME PASSED DIRECTLY TO SHAREHOLDERS	(19,405)
INTEREST INCOME PASSED DIRECTLY TO SHAREHOLDERS	(854)
TAXABLE INCOME	$ 96,011

PAGE 23 - SCHEDULE XX - QUESTION 12

SALARY COSTS ALLOCATED TO DEPARTMENTS WORKED BASED UPON TIME CARDS.

* RELATED PARTY ACCOUNTS PAYABLE NOT ALL FOR TAX PURPOSES INCLUDED HERE FOR CONS WITH PRIOR COST REPORTS AND TO CONFORM ACCRUAL ACCOUNTING METHODS.

LOWED
SISTENCY
TO

PAGE 6 SCHEDULE VII B LINE 2
NURSING HOME MANAGERS COSTS

CENTRAL OFFICE COST ALLOCATION
HILLTOP
2002

	AUG 02	SEPT	OCT	NOV	DEC	JAN 03	FEB	MARCH	APRIL	MAY	JUNE	JULY	2002 TOTAL	LINE
SALARIES-ADMIN	$1,840	$1,912	$1,973	$2,041	$2,237	$2,331	$2,389	$2,367	$2,387	$2,303	$2,344	$2,355	$26,480	17
SALARIES-CLERIC	1,331	1,383	1,427	1,476	1,618	1,700	1,742	1,726	1,741	1,679	1,710	1,717	19,251	21
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0	11
SALARIES-NURSE	137	142	147	152	166	425	436	432	435	420	427	429	3,748	10
ACCOUNTING	49	51	53	55	60	156	160	159	160	154	157	158	1,371	19
WORK COMP INS	18	19	19	20	22	29	29	29	29	28	29	29	300	22
SUPPLIES	111	115	119	123	135	124	128	126	127	123	125	126	1,483	21
TELEPHONE	73	76	79	82	89	124	128	126	127	123	125	126	1,279	21
EMPL BENEFITS	691	718	741	766	840	688	706	699	705	680	692	695	8,620	22
PAYROLL TAXES	230	239	247	255	279	379	388	385	388	374	381	383	3,927	22
TRAVEL	29	30	31	32	35	59	61	60	61	59	60	60	578	24
IN SERVICE	71	74	76	79	87	56	58	57	58	56	57	57	785	23
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0	
MACHINE RENTAL	13	14	14	15	16	46	47	46	47	45	46	46	394	6
OWNERS COMP	118	123	127	131	144	150	153	152	153	148	151	151	1,702	17
INS-PROP,LIAB,WC	6	7	7	7	8	19	19	19	19	19	19	19	168	26
DEPRECIATION	59	61	63	65	71	114	117	116	117	113	115	116	1,127	30
RENT	243	253	261	270	296	315	323	320	323	312	317	319	3,552	34
MAINTENANCE	54	56	58	60	65	57	58	58	58	56	57	57	694	6
FEES & PUBLICAT	0	0	0	0	0	0	0	0	0	0	0	0	0	20
ADVERTISING	3	3	3	3	3	0	0	0	0	0	0	0	14	20
	0	0	0	0	0	0	0	0	0	0	0	0	0	
TOTAL	$5,077	$5,275	$5,444	$5,632	$6,171	$6,772	$6,942	$6,877	$6,937	$6,692	$6,812	$6,843	$75,473	
FIXED ASSETS													75,473	
EQUIP - PRIOR	7,998	8,309	8,575	8,871	9,721	11,330	11,614	7,620	7,686	7,414	7,548	7,582	8,689	
EQUIP - CURR	739	767	792	819	898	0	0	3,273	3,302	3,185	3,242	3,257	1,689	
EQUIP - FULLY DEP	2,670	2,774	2,863	2,962	3,246	3,463	3,550	3,517	3,548	3,422	3,484	3,499	3,250	
BLDG - PRIOR	941	977	1,008	1,043	1,143	1,220	1,250	1,239	1,250	1,205	1,227	1,233	1,145	
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0	
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0	

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	14.05%	13.99%	22.07%	16.09%	12.99%	20.82%	100.00%
SALARIES-ADMIN	$1,849	$1,840	$2,904	$2,117	$1,709	$2,739	$13,158
SALARIES-CLERIC	1,337	1,331	2,100	1,531	1,236	1,981	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	137	137	216	157	127	204	978
ACCOUNTING	49	49	78	57	46	73	352
WORK COMP INS	18	18	28	21	17	27	128
SUPPLIES	111	111	175	128	103	165	794
TELEPHONE	74	73	116	85	68	109	525
EMPL BENEFITS	694	691	1,090	794	641	1,028	4,938
PAYROLL TAXES	231	230	363	264	213	342	1,644
TRAVEL	29	29	46	33	27	43	208
IN SERVICE	72	71	113	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	13	21	15	12	20	95
OWNERS COMP	119	118	187	136	110	176	847
INS-PROP,LIAB,WC	6	6	10	7	6	9	45
DEPRECIATION	59	59	92	67	54	87	419
RENT	244	243	384	280	226	362	1,739
MAINTENANCE	54	54	85	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$5,100	$5,077	$8,012	$5,839	$4,714	$7,558	$36,300
FIXED ASSETS							
EQUIP - PRIOR	8,033	7,998	12,620	9,198	7,426	11,905	57,179
EQUIP - CURR	742	739	1,166	850	686	1,100	5,281
EQUIP - FULLY DEP	2,682	2,670	4,214	3,071	2,479	3,975	19,092
BLDG - PRIOR	945	941	1,484	1,082	873	1,400	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	13.70%	14.53%	21.89%	16.16%	13.00%	20.71%	100.00%
SALARIES-ADMIN	$1,803	$1,912	$2,881	$2,127	$1,710	$2,725	$13,158
SALARIES-CLERIC	1,304	1,383	2,084	1,538	1,237	1,971	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	134	142	214	158	127	203	978
ACCOUNTING	48	51	77	57	46	73	352
WORK COMP INS	18	19	28	21	17	27	128
SUPPLIES	109	115	174	128	103	164	794
TELEPHONE	72	76	115	85	68	109	525
EMPL BENEFITS	677	718	1,081	798	642	1,023	4,938
PAYROLL TAXES	225	239	360	266	214	340	1,644
TRAVEL	28	30	45	34	27	43	208
IN SERVICE	70	74	112	82	66	106	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	13	14	21	15	12	20	95
OWNERS COMP	116	123	185	137	110	175	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	57	61	92	68	54	87	419
RENT	238	253	381	281	226	360	1,739
MAINTENANCE	53	56	84	62	50	80	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	3	3	4	3	2	4	19
	0	0	0	0	0	0	0
TOTAL	$4,975	$5,275	$7,947	$5,868	$4,718	$7,517	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,836	8,309	12,518	9,243	7,432	11,841	57,179
EQUIP - CURR	724	767	1,156	854	686	1,094	5,281
EQUIP - FULLY DEP	2,617	2,774	4,180	3,086	2,482	3,954	19,092
BLDG - PRIOR	922	977	1,472	1,087	874	1,393	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.95%	15.00%	21.53%	16.58%	13.53%	20.41%	100.00%
SALARIES-ADMIN	$1,704	$1,973	$2,833	$2,182	$1,780	$2,685	$13,158
SALARIES-CLERIC	1,233	1,427	2,049	1,578	1,288	1,942	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	127	147	211	162	132	200	978
ACCOUNTING	46	53	76	58	48	72	352
WORK COMP INS	17	19	28	21	17	26	128
SUPPLIES	103	119	171	132	107	162	794
TELEPHONE	68	79	113	87	71	107	525
EMPL BENEFITS	640	741	1,063	819	668	1,008	4,938
PAYROLL TAXES	213	247	354	273	222	335	1,644
TRAVEL	27	31	45	34	28	42	208
IN SERVICE	66	76	110	85	69	104	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	14	20	16	13	19	95
OWNERS COMP	110	127	182	140	115	173	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	54	63	90	69	57	86	419
RENT	225	261	374	288	235	355	1,739
MAINTENANCE	50	58	83	64	52	78	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,702	$5,444	$7,815	$6,019	$4,912	$7,408	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,407	8,575	12,310	9,481	7,737	11,669	57,179
EQUIP - CURR	684	792	1,137	876	715	1,078	5,281
EQUIP - FULLY DEP	2,473	2,863	4,110	3,166	2,583	3,896	19,092
BLDG - PRIOR	871	1,008	1,448	1,115	910	1,372	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	12.31%	15.51%	22.10%	16.54%	13.40%	20.14%	100.00%
SALARIES-ADMIN	$1,619	$2,041	$2,908	$2,176	$1,763	$2,650	$13,158
SALARIES-CLERIC	1,171	1,476	2,104	1,574	1,275	1,917	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	120	152	216	162	131	197	978
ACCOUNTING	43	55	78	58	47	71	352
WORK COMP INS	16	20	28	21	17	26	128
SUPPLIES	98	123	175	131	106	160	794
TELEPHONE	65	82	116	87	70	106	525
EMPL BENEFITS	608	766	1,092	817	662	995	4,938
PAYROLL TAXES	202	255	363	272	220	331	1,644
TRAVEL	26	32	46	34	28	42	208
IN SERVICE	63	79	113	84	68	103	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	12	15	21	16	13	19	95
OWNERS COMP	104	131	187	140	113	171	847
INS-PROP,LIAB,WC	6	7	10	7	6	9	45
DEPRECIATION	52	65	93	69	56	84	419
RENT	214	270	384	288	233	350	1,739
MAINTENANCE	47	60	85	64	52	77	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	2	3	4	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$4,468	$5,632	$8,024	$6,003	$4,864	$7,311	$36,300
FIXED ASSETS							
EQUIP - PRIOR	7,037	8,871	12,639	9,455	7,662	11,515	57,179
EQUIP - CURR	650	819	1,167	873	708	1,064	5,281
EQUIP - FULLY DEP	2,350	2,962	4,220	3,157	2,558	3,845	19,092
BLDG - PRIOR	828	1,043	1,486	1,112	901	1,354	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 2002

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	4.42%	17.00%	23.85%	17.58%	14.54%	22.61%	100.00%
SALARIES-ADMIN	$582	$2,237	$3,138	$2,313	$1,913	$2,975	$13,158
SALARIES-CLERIC	421	1,618	2,269	1,673	1,384	2,151	9,517
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	43	166	233	172	142	221	978
ACCOUNTING	16	60	84	62	51	80	352
WORK COMP INS	6	22	31	23	19	29	128
SUPPLIES	35	135	189	140	115	179	794
TELEPHONE	23	89	125	92	76	119	525
EMPL BENEFITS	218	840	1,178	868	718	1,116	4,938
PAYROLL TAXES	73	279	392	289	239	372	1,644
TRAVEL	9	35	50	37	30	47	208
IN SERVICE	23	87	122	90	74	115	510
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	4	16	23	17	14	21	95
OWNERS COMP	37	144	202	149	123	191	847
INS-PROP,LIAB,WC	2	8	11	8	7	10	45
DEPRECIATION	19	71	100	74	61	95	419
RENT	77	296	415	306	253	393	1,739
MAINTENANCE	17	65	92	68	56	87	385
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	1	3	5	3	3	4	19
	0	0	0	0	0	0	0
TOTAL	$1,606	$6,171	$8,656	$6,382	$5,278	$8,206	$36,300
FIXED ASSETS							
EQUIP - PRIOR	2,530	9,721	13,635	10,053	8,314	12,926	57,179
EQUIP - CURR	234	898	1,259	929	768	1,194	5,281
EQUIP - FULLY DEP	845	3,246	4,553	3,357	2,776	4,316	19,092
BLDG - PRIOR	298	1,143	1,604	1,182	978	1,520	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,331	$3,344	$2,356	$1,857	$2,961	$12,848
SALARIES-CLERIC	0	1,700	2,439	1,718	1,354	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	425	610	429	339	540	$2,343
ACCOUNTING	0	156	224	158	124	198	$861
WORK COMP INS	0	29	41	29	23	36	$158
SUPPLIES	0	124	179	126	99	158	$686
TELEPHONE	0	124	179	126	99	158	$686
EMPL BENEFITS	0	688	988	696	548	875	$3,795
PAYROLL TAXES	0	379	543	383	302	481	$2,087
TRAVEL	0	59	85	60	47	76	$328
IN SERVICE	0	56	81	57	45	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	65	46	36	58	$251
OWNERS COMP	0	150	215	151	119	190	$825
INS-PROP,LIAB,WC	0	19	27	19	15	24	$104
DEPRECIATION	0	114	164	116	91	145	$631
RENT	0	315	453	319	251	401	$1,739
MAINTENANCE	0	57	82	57	45	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,772	$9,717	$6,845	$5,395	$8,605	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,330	16,257	11,451	9,026	14,396	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,463	4,969	3,500	2,759	4,400	19,092
BLDG - PRIOR	0	1,220	1,750	1,233	972	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
SALARIES-ADMIN	$0	$2,389	$3,358	$2,414	$1,725	$2,962	$12,848
SALARIES-CLERIC	0	1,742	2,449	1,761	1,258	2,160	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	436	612	440	315	540	$2,343
ACCOUNTING	0	160	225	162	116	198	$861
WORK COMP INS	0	29	41	30	21	36	$158
SUPPLIES	0	128	179	129	92	158	$686
TELEPHONE	0	128	179	129	92	158	$686
EMPL BENEFITS	0	706	992	713	510	875	$3,795
PAYROLL TAXES	0	388	545	392	280	481	$2,087
TRAVEL	0	61	86	62	44	76	$328
IN SERVICE	0	58	81	58	42	71	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	66	47	34	58	$251
OWNERS COMP	0	153	216	155	111	190	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	117	165	118	85	145	$631
RENT	0	323	454	327	234	401	$1,739
MAINTENANCE	0	58	82	59	42	72	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,942	$9,757	$7,015	$5,014	$8,607	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	11,614	16,322	11,736	8,388	14,400	62,460
EQUIP - CURR	0	0	0	0	0	0	0
EQUIP - FULLY DEP	0	3,550	4,989	3,587	2,564	4,402	19,092
BLDG - PRIOR	0	1,250	1,757	1,264	903	1,550	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
SALARIES-ADMIN	$0	$2,367	$3,404	$2,494	$1,677	$2,906	$12,848
SALARIES-CLERIC	0	1,726	2,482	1,819	1,223	2,119	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	432	621	455	306	530	$2,343
ACCOUNTING	0	159	228	167	112	195	$861
WORK COMP INS	0	29	42	31	21	36	$158
SUPPLIES	0	126	182	133	90	155	$686
TELEPHONE	0	126	182	133	90	155	$686
EMPL BENEFITS	0	699	1,005	737	495	858	$3,795
PAYROLL TAXES	0	385	553	405	273	472	$2,087
TRAVEL	0	60	87	64	43	74	$328
IN SERVICE	0	57	82	60	40	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	46	66	49	33	57	$251
OWNERS COMP	0	152	219	160	108	187	$825
INS-PROP,LIAB,WC	0	19	28	20	14	24	$104
DEPRECIATION	0	116	167	122	82	143	$631
RENT	0	320	461	338	227	393	$1,739
MAINTENANCE	0	58	83	61	41	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,877	$9,891	$7,248	$4,874	$8,444	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,620	10,959	8,030	5,400	9,356	41,365
EQUIP - CURR	0	3,273	4,707	3,449	2,320	4,019	17,768
EQUIP - FULLY DEP	0	3,517	5,058	3,706	2,493	4,318	19,092
BLDG - PRIOR	0	1,239	1,782	1,306	878	1,521	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
SALARIES-ADMIN	$0	$2,387	$3,303	$2,542	$1,725	$2,891	$12,848
SALARIES-CLERIC	0	1,741	2,409	1,854	1,258	2,108	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	435	602	463	315	527	$2,343
ACCOUNTING	0	160	221	170	116	194	$861
WORK COMP INS	0	29	41	31	21	36	$158
SUPPLIES	0	127	176	136	92	154	$686
TELEPHONE	0	127	176	136	92	154	$686
EMPL BENEFITS	0	705	975	751	510	854	$3,795
PAYROLL TAXES	0	388	537	413	280	470	$2,087
TRAVEL	0	61	84	65	44	74	$328
IN SERVICE	0	58	80	61	42	70	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	47	65	50	34	56	$251
OWNERS COMP	0	153	212	163	111	186	$825
INS-PROP,LIAB,WC	0	19	27	21	14	23	$104
DEPRECIATION	0	117	162	125	85	142	$631
RENT	0	323	447	344	234	391	$1,739
MAINTENANCE	0	58	81	62	42	71	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,937	$9,597	$7,387	$5,013	$8,400	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,686	10,633	8,184	5,554	9,307	41,365
EQUIP - CURR	0	3,302	4,567	3,515	2,386	3,998	17,768
EQUIP - FULLY DEP	0	3,548	4,908	3,777	2,564	4,296	19,092
BLDG - PRIOR	0	1,250	1,729	1,331	903	1,513	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
SALARIES-ADMIN	$0	$2,303	$3,381	$2,444	$1,734	$2,987	$12,848
SALARIES-CLERIC	0	1,679	2,465	1,782	1,265	2,179	$9,370
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	420	616	446	316	545	$2,343
ACCOUNTING	0	154	226	164	116	200	$861
WORK COMP INS	0	28	42	30	21	37	$158
SUPPLIES	0	123	180	130	93	159	$686
TELEPHONE	0	123	181	131	93	160	$686
EMPL BENEFITS	0	680	998	722	512	882	$3,795
PAYROLL TAXES	0	374	549	397	282	485	$2,087
TRAVEL	0	59	86	62	44	76	$328
IN SERVICE	0	56	82	59	42	72	$310
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	0	45	66	48	34	58	$251
OWNERS COMP	0	148	217	157	111	192	$825
INS-PROP,LIAB,WC	0	19	27	20	14	24	$104
DEPRECIATION	0	113	166	120	85	147	$631
RENT	0	312	458	331	235	404	$1,739
MAINTENANCE	0	56	82	60	42	73	$313
FEES & PUBLIC	0	0	0	0	0	0	$0
ADVERTISING	0	0	0	0	0	0	$0
	0	0	0	0	0	0	$0
TOTAL	$0	$6,692	$9,823	$7,101	$5,039	$8,680	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,414	10,883	7,867	5,583	9,617	41,365
EQUIP - CURR	0	3,185	4,675	3,379	2,398	4,131	17,768
EQUIP - FULLY DEP	0	3,422	5,023	3,631	2,577	4,439	19,092
BLDG - PRIOR	0	1,205	1,769	1,279	908	1,564	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
SALARIES-ADMIN	$0	$2,344	$3,318	$2,439	$1,780	$2,967	$12,848
SALARIES-CLERIC	0	1,710	2,419	1,778	1,298	2,164	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	427	605	445	325	541	2,343
ACCOUNTING	0	157	222	163	119	199	861
WORK COMP INS	0	29	41	30	22	37	158
SUPPLIES	0	125	177	130	95	158	686
TELEPHONE	0	125	177	130	95	158	686
EMPL BENEFITS	0	692	980	720	526	876	3,795
PAYROLL TAXES	0	381	539	396	289	482	2,087
TRAVEL	0	60	85	62	45	76	328
IN SERVICE	0	57	80	59	43	72	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	65	48	35	58	251
OWNERS COMP	0	151	213	157	114	191	825
INS-PROP,LIAB,WC	0	19	27	20	14	24	104
DEPRECIATION	0	115	163	120	87	146	631
RENT	0	317	449	330	241	402	1,739
MAINTENANCE	0	57	81	59	43	72	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,812	$9,640	$7,086	$5,174	$8,623	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,548	10,681	7,851	5,732	9,553	41,365
EQUIP - CURR	0	3,242	4,588	3,372	2,462	4,104	17,768
EQUIP - FULLY DEP	0	3,484	4,930	3,624	2,646	4,409	19,092
BLDG - PRIOR	0	1,227	1,736	1,276	932	1,553	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JULY 2003

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
SALARIES-ADMIN	$0	$2,355	$3,461	$2,449	$1,728	$2,855	$12,848
SALARIES-CLERIC	0	1,717	2,524	1,786	1,260	2,082	9,370
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	429	631	447	315	521	2,343
ACCOUNTING	0	158	232	164	116	191	861
WORK COMP INS	0	29	43	30	21	35	158
SUPPLIES	0	126	185	131	92	152	686
TELEPHONE	0	126	185	131	92	152	686
EMPL BENEFITS	0	695	1,022	723	510	843	3,795
PAYROLL TAXES	0	383	562	398	281	464	2,087
TRAVEL	0	60	88	62	44	73	328
IN SERVICE	0	57	84	59	42	69	310
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	0	46	68	48	34	56	251
OWNERS COMP	0	151	222	157	111	183	825
INS-PROP,LIAB,WC	0	19	28	20	14	23	104
DEPRECIATION	0	116	170	120	85	140	631
RENT	0	319	468	332	234	386	1,739
MAINTENANCE	0	57	84	60	42	70	313
FEES & PUBLIC	0	0	0	0	0	0	0
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$0	$6,843	$10,057	$7,117	$5,021	$8,297	$37,335
FIXED ASSETS							
EQUIP - PRIOR	0	7,582	11,142	7,886	5,563	9,193	41,365
EQUIP - CURR	0	3,257	4,786	3,387	2,389	3,949	17,768
EQUIP - FULLY DEP	0	3,499	5,143	3,640	2,567	4,243	19,092
BLDG - PRIOR	0	1,233	1,812	1,282	904	1,495	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

ALLOCATION PERCENTAGES USED ON PAGE 27

OCCUPIED DAYS 2002	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY	1,809	1,594	2,447	1,759		1,501	2,396	11,506
FEBRUAR	1,598	1,477	2,246	1,597		1,527	2,172	10,617
MARCH	1,773	1,610	2,506	1,661		1,698	2,330	11,578
APRIL	1,793	1,645	2,422	1,630		1,613	2,281	11,384
MAY	1,910	1,497	2,430	1,734		1,605	2,409	11,585
JUNE	1,795	1,498	2,306	1,758		1,517	2,340	11,214
JULY	1,682	1,617	2,358	1,758		1,622	2,367	11,404
AUGUST	1,573	1,566	2,471	1,801		1,454	2,331	11,196
SEPTEM	1,493	1,583	2,385	1,761		1,416	2,256	10,894
OCTOBER	1,503	1,740	2,498	1,924		1,570	2,368	11,603
NOVEMBE	1,397	1,761	2,509	1,877		1,521	2,286	11,351
DECEMBE	464	1,783	2,501	1,844		1,525	2,371	10,488
TOTAL	18,790	19,371	29,079	21,104	0	18,569	27,907	134,820
								134,820

OCCUPIED DAYS 2003	D'ADR	HLTP	JVILLE	MEAD M	MMW	MENARD	SUNRISE	TOTAL
JANUARY		1,766	2,534	1,785		1,407	2,244	9,736
FEBRUARY		1,613	2,267	1,630		1,165	2,000	8,675
MARCH		1,782	2,563	1,878		1,263	2,188	9,674
APRIL		1,745	2,414	1,858		1,261	2,113	9,391
MAY		1,733	2,544	1,839		1,305	2,248	9,669
JUNE		1,667	2,359	1,734		1,266	2,110	9,136
JULY		1,746	2,566	1,816		1,281	2,117	9,526
AUGUST		1,752	2,566	1,744		1,428	2,070	9,560
SEPTEM								0
OCTOBER								0
NOVEMBER								0
DECEMBER								0
TOTAL	0	13,804	19,813	14,284	0	10,376	17,090	75,367
								75,367

ALLOCATION PERCENTAGE 2002	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	15.72%	13.85%	21.27%	15.29%	13.05%	20.82%	100.00%
FEBRUARY	15.05%	13.91%	21.15%	15.04%	14.38%	20.46%	100.00%
MARCH	15.31%	13.91%	21.64%	14.35%	14.67%	20.12%	100.00%
APRIL	15.75%	14.45%	21.28%	14.32%	14.17%	20.04%	100.00%
MAY	16.49%	12.92%	20.98%	14.97%	13.85%	20.79%	100.00%
JUNE	16.01%	13.36%	20.56%	15.68%	13.53%	20.87%	100.00%
JULY	14.75%	14.18%	20.68%	15.42%	14.22%	20.76%	100.00%
AUGUST	14.05%	13.99%	22.07%	16.09%	12.99%	20.82%	100.00%
SEPTEMBER	13.70%	14.53%	21.89%	16.16%	13.00%	20.71%	100.00%
OCTOBER	12.95%	15.00%	21.53%	16.58%	13.53%	20.41%	100.00%
NOVEMBER	12.31%	15.51%	22.10%	16.54%	13.40%	20.14%	100.00%
DECEMBER	4.42%	17.00%	23.85%	17.58%	14.54%	22.61%	100.00%

ALLOCATION PERCENTAGE 2003	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
JANUARY	0.00%	18.14%	26.03%	18.33%	14.45%	23.05%	100.00%
FEBRUARY	0.00%	18.59%	26.13%	18.79%	13.43%	23.05%	100.00%
MARCH	0.00%	18.42%	26.49%	19.41%	13.06%	22.62%	100.00%
APRIL	0.00%	18.58%	25.71%	19.78%	13.43%	22.50%	100.00%
MAY	0.00%	17.92%	26.31%	19.02%	13.50%	23.25%	100.00%
JUNE	0.00%	18.25%	25.82%	18.98%	13.86%	23.10%	100.00%
JULY	0.00%	18.33%	26.94%	19.06%	13.45%	22.22%	100.00%
AUGUST	0.00%	18.33%	26.84%	18.24%	14.94%	21.65%	100.00%